Supporting Statement For Paperwork Reduction Act Submissions

A. Background

Many LTCHs are co-located with other Medicare providers (acute care hospitals, IRFs, SNFs, psychiatric facilities), which leads to potential gaming of the Medicare system based on patient shifting. CMS is requiring LTCHs to notify FIs and CMS of co-located providers and has established policies to limit payment abuse that will be based on FIs tracking patient movement among these co-located providers.

B. Justification

1 . Need and Legal Basis

Many LTCHs are co-located with other Medicare providers (acute care hospitals, IRFs, SNFs, psychiatric facilities), which leads to potential gaming of the Medicare system based on patient shifting. CMS is requiring LTCHs to notify FIs and CMS of co-located providers and has established policies to limit payment abuse that will be based on FIs tracking patient movement among these co-located providers 42 CFR 412.22(e)(6) and (h)(5).

2. Information Users

FIs and CMS will be able to track co-located status of LTCHs which will lead to appropriate payments under 412.532 which to avoid payment abuses, limits payments to LTCHs where over 5% of admissions represent patients who had been sequentially discharged by the LTCH, admitted to an on-site provider, and subsequently readmitted to the LTCH.

3. Use of Information Technology

A. CMS is requiring that FIs monitor co-location among their LTCHs but has not established any format for information storage.

The LTCH PPS was implemented on October 1, 2002. CMS anticipates that as policies and procedures are refined, there will be increasing use of electronic information gathering and storage.

*To comply with the Government Paperwork Elimination Act (GPEA), you must also include the following information in this section:

- Is this collection currently available for completion electronically?
  N/A
- Does this collection require a signature from the respondent(s)?
  N/A
  - If CMS had the capability of accepting electronic signature(s), could this collection be

- made available electronically?

N/A

- If this collection isn't currently electronic but will be made electronic in the future, please give a date (month & year) as to when this will be available electronically and explain why it can't be done sooner.

This new system was effective on October 1, 2002 but the systems (claims-processing) component has only been "up" since January 1, 2003. CMS will notify FIs of the desirability of electronic data collection and CMS preference for information storage in electronically transmissible data bases as PPS policies become established through the transition period.

A. Each LTCH must determine whether or not to opt out of the transition to PPS payments. CMS specified timing rules by which individual LTCHs could notify FIs of this election in writing.

B. LTCHs are able to transmit information on their co-located status to FIs and CMS electronically.

4. Duplication of Efforts

In both cases, these information collections do not duplicate any other effort and the information cannot be obtained from any other source.

5. Small Businesses

This does not have a significant economic impact on small businesses.

6. Less Frequent Collection

Specific payment policies under the LTCH PPS will be unenforceable without collection of this data as set forth in the LTCH PPS August 30, 2002 final rule.

7. Special Circumstances

There are no special circumstances.

8. Federal Register/Outside Consultation

The 60-day Federal Register notice for this information collection published on September 1, 2006.

9. Payments/Gifts to Respondents

There are not payments or gifts to respondents.

10. Confidentiality

N/A

11. Sensitive Questions

N/A

12. Burden Estimates (Hours & Wages)

§412.533(b) Transition payments: Election not to be paid under the transitional period methodology.

Under §412.533(b), a LTCH may elect to be paid based on 100 percent of the Federal prospective payment rate at the start of any of its cost reporting periods during a 5-year transition period beginning on or after October 1, 2002, and before October 1, 2007, without regard to the transitional percentages. Section 412.533(b) specifies that the request to make the election must be made in writing to the Medicare intermediary by the LTCH and received no later than November 1, 2002 for cost reporting periods beginning on or after October 1, 2002 through November 30, 2002 and no later than 30 days before the beginning of the cost reporting period for cost reporting periods beginning on or after December 1, 2002.

We estimate that 94 LTCHs would make a request to elect to receive the full Federal prospective payment rate and that it would take each LTCH approximately 15 minutes each to prepare and submit their written request, for a total estimated annual burden of 24 hours.

Based on comments received and our analysis of planned monitoring activities, in this final rule we have added an additional requirement regarding collection of information at §412.22 concerning a LTCH's (or a LTCH satellite's) notification to its Medicare fiscal intermediary and CMS of its co-located status. Under §§412.22(e)(6) and (h)(5), a LTCH or a satellite of a LTCH that occupies space in a building used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital must notify its fiscal intermediary and CMS in writing of its co-location within 60 days of its first cost reporting period that begins on or after October 1, 2002.

We estimate that the burden associated with this provision is the time it would take for a LTCH or a satellite of a LTCH to prepare and submit its notification to its fiscal intermediary and CMS. At this time, we estimate that 100 LTCHs and satellites of LTCHs will take 15 minutes each to comply with these provisions for a total burden of 25 hours. The total burden associated with the collection requirements referenced in this rule is 49 annual hours.

13. Capital Costs

No annualized costs are expected for implementation of the data collection elements of the policies.

14. Cost to Federal Government

N/A

15. Changes to Burden

    The increase in hours is attributed to an increase in the number of hospitals within hospitals (HwH) and satellites.

16. Publication/Tabulation Dates

    N/A

17. Expiration Date

    This collection does not lend itself to the displaying of an expiration date.

18. Certification Statement

    No exceptions are requested.

B. Collections of Information Employing Statistical Methods

This collection does not employ statistical methods.

Sec. 412.**22** Excluded hospitals and hospital units: General rules.

(a) Criteria. Subject to the criteria set forth in paragraph (e) of this section, a hospital is excluded from the prospective payment systems specified in Sec. 412.1(a)(1) of this part if it meets the criteria for one or more of the excluded classifications described in Sec. 412.23.

(b) Cost reimbursement. Except for those hospitals specified in paragraph (c) of this section and Secs. 412.20(b) and (c), all excluded hospitals (and excluded hospital units, as described in Secs. 412.23 through 412.29) are reimbursed under the cost reimbursement rules set forth in part 413 of this subchapter, and are subject to the ceiling on the rate of hospital cost increases described in Sec. 413.40 of this subchapter.

(c) Special payment provisions. The following classifications of hospitals are paid under special provisions and therefore are not generally subject to the cost reimbursement or prospective payment rules of this chapter.

(1) Veterans Administration hospitals.

(2) Hospitals reimbursed under State cost control systems approved under part 403 of this chapter.

(3) Hospitals reimbursed in accordance with demonstration projects authorized under section 402(a) of Public Law 90-248 (42 U.S.C. 1395b-1) or section 222(a) of Public Law 92-603 (42 U.S.C. 1395b-1 (note)).

(4) Nonparticipating hospitals furnishing emergency services to Medicare beneficiaries.

(d) Changes in hospitals' status. For purposes of exclusion from the prospective payment systems under this subpart, the status of each currently participating hospital (excluded or not excluded) is determined at the beginning of each cost reporting period and is effective for the entire cost reporting period. Any changes in the status of the hospital are made only at the start of a cost reporting period.

(e) Hospitals within hospitals. Except as provided in paragraph (f) of this section, for cost reporting periods beginning on or after October 1, 1997, a hospital that occupies space in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital, must meet the following criteria in order to be excluded from the prospective payment systems specified in Sec. 412.1(a)(1):

(1) Separate governing body. The hospital has a governing body that is separate from the governing body of the hospital occupying space in the same building or on the same campus. The hospital's governing body is not under the control of the hospital occupying space in the same building or on the same campus, or of any third entity that controls both hospitals.

(2) Separate chief medical officer. The hospital has a single chief medical officer who reports directly to the governing body and who is responsible for all medical staff activities of the hospital. The chief medical officer of the hospital is not employed by or under contract with either the hospital occupying space in the same building or on the

same campus or any third entity that controls both hospitals.

(3) Separate medical staff. The hospital has a medical staff that is separate from the medical staff of the hospital occupying space in the same building or on the same campus. The hospital's medical staff is directly accountable to the governing body for the quality of medical care provided in the hospital, and adopts and enforces bylaws governing medical staff activities, including criteria and procedures for recommending to the governing body the privileges to be granted to individual practitioners.

(4) Chief executive officer. The hospital has a single chief executive officer through whom all administrative authority flows, and who exercises control and surveillance over all administrative activities of the hospital. The chief executive officer is not employed by, or under contract with, either the hospital occupying space in the same building or on the same campus or any third entity that controls both hospitals.

(5) Performance of basic hospital functions. The hospital meets one of the following criteria:

(i) The hospital performs the basic functions specified in Secs. 482.21 through 482.27, 482.30, and 482.42 of this chapter through the use of employees or under contracts or other agreements with entities other than the hospital occupying space in the same building or on the same campus, or a third entity that controls both hospitals. Food and dietetic services and housekeeping, maintenance, and other services necessary to maintain a clean and safe physical environment could be obtained under contracts or other agreements with the hospital occupying space in the same building or on the same campus, or with a third entity that controls both hospitals.

(ii) For the same period of at least 6 months used to determine compliance with the criterion regarding the age of patients in Sec. 412.23(d)(2) or the length-of-stay criterion in Sec. 412.23(e)(2), or for hospitals other than children's or long-term care hospitals, for a period of at least 6 months immediately preceding the first cost reporting period for which exclusion is sought, the cost of the services that the hospital obtained under contracts or other agreements with the hospital occupying space in the same building or on the same campus, or with a third entity that controls both hospitals, is no more than 15 percent of the hospital's total inpatient operating costs, as defined in Sec. 412.2(c). For purposes of this paragraph (e)(5)(ii), however, the costs of preadmission services are those specified under Sec. 413.40(c)(2) rather than those specified under Sec. 412.2(c)(5).

(iii) For the same period of at least 6 months used to determine compliance with the criterion regarding the age of inpatients in Sec. 412.23(d)(2) or the length-of-stay criterion in Sec. 412.23(e)(2), or for hospitals other than children's or long-term care hospitals, for the period of at least 6 months immediately preceding the first cost reporting period for which exclusion is sought, the hospital has an inpatient population of whom at least 75 percent were referred to the hospital from a source other than another hospital occupying space in the same building or on the same campus.

(6) Notification of co-located status. A long-term care hospital that occupies space in a building used by another hospital, or in one or more entire buildings located on the same campus as buildings used by

another hospital and that meets the criteria of paragraphs (e)(1) through (e)(5) of this section must notify its fiscal intermediary and CMS in writing of its co-location within 60 days of its first cost reporting period that begins on or after October 1, 2002.

(f) Application for certain hospitals. If a hospital was excluded from the prospective payment systems under the provisions of this section on or before September 30, 1995, and at that time occupied space in a building also used by another hospital, or in one or more buildings located on the same campus as buildings used by another hospital, the criteria in paragraph (e) of this section do not apply to the hospital.

(g) Definition of control. For purposes of this section, control exists if an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

(h) Satellite facilities. (1) For purposes of paragraphs (h)(2) through (h)(4) of this section, a satellite facility is a part of a hospital that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital.

(2) Except as provided in paragraph (h)(3) of this section, effective for cost reporting periods beginning on or after October 1, 1999, a hospital that has a satellite facility must meet the following criteria in order to be excluded from the acute care hospital inpatient prospective payment systems for any period:

(i) In the case of a hospital (other than a children's hospital) that was excluded from the prospective payment systems for the most recent cost reporting period beginning before October 1, 1997, the hospital's number of State-licensed and Medicare-certified beds, including those at the satellite facilities, does not exceed the hospital's number of State-licensed and Medicare-certified beds on the last day of the hospital's last cost reporting period beginning before October 1, 1997.

(ii) The satellite facility independently complies with--

(A) For psychiatric hospitals, the requirements under Sec. 412.23(a);

(B) For rehabilitation hospitals, the requirements under Sec. 412.23(b)(2);

(C) For children's hospitals, the requirements under Sec. 412.23(d)(2); or

(D) For long-term care hospitals, the requirements under Secs. 412.23(e)(1) through (e)(3)(i).

(iii) The satellite facility meets all of the following requirements:

(A) Effective for cost reporting periods beginning on or after October 1, 2002, it is not under the control of the governing body or chief executive officer of the hospital in which it is located, and it furnishes inpatient care through the use of medical personnel who are not under the control of the medical staff or chief medical officer of the hospital in which it is located.

(B) It maintains admission and discharge records that are separately identified from those of the hospital in which it is located and are readily available.

(C) It has beds that are physically separate from (that is, not

commingled with) the beds of the hospital in which it is located.

(D) It is serviced by the same fiscal intermediary as the hospital of which it is a part.

(E) It is treated as a separate cost center of the hospital of which it is a part.

(F) For cost reporting and apportionment purposes, it uses an accounting system that properly allocates costs and maintains adequate statistical data to support the basis of allocation.

(G) It reports its costs on the cost report of the hospital of which it is a part, covering the same fiscal period and using the same method of apportionment as the hospital of which it is a part.

(3) Except as provided in paragraph (h)(4) of this section, the provisions of paragraph (h)(2) of this section do not apply to--

(i) Any hospital structured as a satellite facility on September 30, 1999, and excluded from the prospective payment systems on that date, to the extent the hospital continues operating under the same terms and conditions, including the number of beds and square footage considered, for purposes of Medicare participation and payment, to be part of the hospital, in effect on September 30, 1999; or

(ii) Any hospital excluded from the prospective payment systems under Sec. 412.23(e)(2).

(4) In applying the provisions of paragraph (h)(3) of this section, any hospital structured as a satellite facility on September 30, 1999, may increase or decrease the square footage of the satellite facility or may decrease the number of beds in the satellite facility if these changes are made necessary by relocation of a facility--

(i) To permit construction or renovation necessary for compliance with changes in Federal, State, or local law; or

(ii) Because of catastrophic events such as fires, floods, earthquakes, or tornadoes.

(5) Notification of co-located status. A satellite of a long-term care hospital that occupies space in a building used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital and that meets the criteria of paragraphs (h)(1) through (h)(4) of this section must notify its fiscal intermediary and CMS in writing of its co-location within 60 days of its first cost reporting period beginning on or after October 1, 2002.

[50 FR 12741, Mar. 29, 1985, as amended at 51 FR 34793, Sept. 30, 1986; 57 FR 39820, Sept. 1, 1994; 62 FR 46026, Aug. 29, 1997; 63 FR 26357, May 12, 1998; 64 FR 41540, July 30, 1999; 66 FR 41386, Aug. 7, 2001; 67 FR 50111, Aug. 1, 2002; 67 FR 56048, Aug. 30, 2002]

Sec. 412.**533** Transition payments.

(a) Duration of transition periods. Except for a long-term care hospital that makes an election under paragraph (c) of this section or for a long-term care hospital that is defined as new under Sec. 412.23(e)(4), for cost reporting periods beginning on or after October 1, 2002, and before October 1, 2006, a long-term care hospital receives a payment comprised of a blend of the adjusted Federal prospective payment as determined under Sec. 412.523, and the payment determined under the cost-based reimbursement rules under Part 413 of

this subchapter.

(1) For cost reporting periods beginning on or after October 1, 2002 and before October 1, 2003, payment is based on 20 percent of the Federal prospective payment rate and 80 percent of the cost-based reimbursement rate.

(2) For cost reporting periods beginning on or after October 1, 2003 and before October 1, 2004, payment is based on 40 percent of the Federal prospective payment rate and 60 percent of the cost-based reimbursement rate.

(3) For cost reporting periods beginning on or after October 1, 2004 and before October 1, 2005, payment is based on 60 percent of the Federal prospective payment rate and 40 percent of the cost-based reimbursement rate.

(4) For cost reporting periods beginning on or after October 1, 2005 and before October 1, 2006, payment is based on 80 percent of the Federal prospective payment rate and 20 percent of the cost-based reimbursement rate.

(5) For cost reporting periods beginning on or after October 1, 2006, payment is based entirely on the adjusted Federal prospective payment rate.

(b) Adjustments based on reconciliation of cost reports. The cost-based percentage of the provider's total Medicare payment under paragraphs (a)(1) through (a)(4) of this section are subject to adjustments based on reconciliation of cost reports.

(c) Election not to be paid under the transition period methodology. A long-term care hospital may elect to be paid based on 100 percent of the Federal prospective rate at the start of any of its cost reporting periods during the 5-year transition periods specified in paragraph (a) of this section. Once a long-term care hospital elects to be paid based on 100 percent of the Federal prospective payment rate, it may not revert to the transition blend.

(1) General requirement. A long-term care hospital must notify its fiscal intermediary of its intent to elect to be paid based on 100 percent of the Federal prospective rate at the start of any of its cost reporting periods during the 5-year transition period specified in paragraph (a) of this section.

(2) Notification requirement to make election.

(i) The request by the long-term care hospital to make the election under paragraph (c)(1) of this section must be made in writing to the Medicare fiscal intermediary.

(ii) For cost reporting periods that begin on or after October 1, 2002 through November 30, 2002, the fiscal intermediary must receive the notification of the election before November 1, 2002.

(iii) For cost reporting periods that begin on or after December 1, 2002 through September 30, 2006, the fiscal intermediary must receive the notification of the election on or before the

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30th day before the applicable cost reporting period begins.

(iv) The fiscal intermediary must receive the notification by the dates specified in paragraphs (c)(2)(ii) and (c)(2)(iii) of this section, regardless of any postmarks or anticipated delivery dates.

Requests received, postmarked, or delivered by other means after the dates specified in paragraphs (c)(2)(ii) and (c)(2)(iii) of this section will not be accepted. If the date specified in paragraphs (c)(2)(ii) and (c)(2)(iii) of this section falls on a day that the postal service or other delivery sources are not open for business, the long-term care hospital is responsible for allowing sufficient time for the delivery of the notification before the deadline.

(v) If a long-term care hospital's notification is not received by the dates specified in paragraphs (c)(2)(ii) and (c)(2)(iii) of this section, payment will be based on the transition period rates specified in paragraphs (a)(1) through (a)(5) of this section.

(d) Payments to new long-term care hospitals. A new long-term care hospital, as defined in Sec. 412.23(e)(4), will be paid based on 100 percent of the standard Federal rate, as described in Sec. 412.523, with no transition payments, as described in Sec. 412.533(a)(1) through (a)(5).